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SOLITUDE

Laugh, and the world laughs with you,
Weep, and you weep alone;
For the sad old earth must borrow its mirth,
But has trouble enough of its own.

Sing, and the hills will answer,
Sigh, it is lost on the air;
The echoes bound to a joyful sound,
But shirk from voicing care.

Rejoice and men will seek you;
Grieve and they turn and go;
They want full measure of all your pleasure,
But they do not need your woe.

Be glad and your friends are many;
Be sad, and you lose them all,
There are none to decline your nectar'd wine,
But alone you must drink life's gall.

Feast, and your halls are crowded;
Fast and the world goes by;
Succeed and give, and it helps you live,
But no man can help you die.

There is room in the halls of pleasure
For a large and lordly train,
But one by one we must all file on
Through the narrow aisles of pain.

—ELLA WHEELER WILCOX.

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The Southern Surgeon

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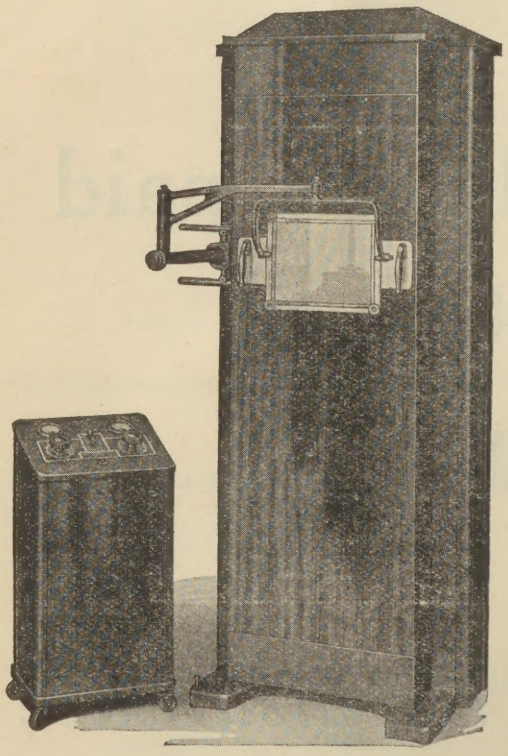

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No man can build a very high structure on some one else's demerits.

Preventive medicine is a problem for the entire profession, not just the county health officers.

We appreciate the paper by Drs. Warr and Gotten on Undulant Fever. They are men who speak with authority.

We are glad to have a discourse from the pen of Dr. Seale Harris of Birmingham. We are always glad to have anything from his pen.

Help us increase the subscription list of The Mississippi Doctor. One dollar for one year in clubs of five or if you subscribe this month. The Mississippi Doctor has a mission. We cover the field of medicine and surgery with papers from men who know. It is readable. It is dependable. It is the champion of The Community Hospital.

Examine your patient from the top of his head to the bottom of his feet, every one of them. Keep up the spirit. Be persistent. Keep on keeping on. You are a part of a great profession. Do not get stale on the job. It is not so much what you do not know, but what you do not do that keeps you from being distinguished in the profession.

The North East Mississippi 13 County Medical Society holds the banner for the community hospital. Watch this society set the example for the United States in bringing modern medicine to the masses at a reasonable price.

Dr. J. G. Mancil has given us a good paper on tonsillitis. Tonsillitis we have with us always. This paper was read before the Delta Medical Society over on the banks of the Father of Waters. Dr. Mancil constitutes one of the many very able professional men in this society.

Let every one go to Amory next Tuesday and do honor to one who has done much for the medical profession in our state, one who emenates a fine medical spirit, one who is a great student and one who has a great vision of the possibilities for service of the medical profession.

During the storm the Aberdeen Hospital took care of forty six victims without one cent cost to any patient. This was a noble piece of work. Some were able to pay, but they had met misfortune in this great cyclone. The people of Aberdeen paid the hospital expense and the doctors did the work without charge. This was a noble piece of professional religion. We commend the medical profession and the citizenry of Aberdeen, that distinguished little city of Southern culture and refinement.

Dr. G. P. Sanderson of Vicksburg has a splendid paper on Pyelitis in this issue of the journal for which we thank him.

The outstanding problem for the gynecologist is to diagnose the potential cancer case and apply his prophylactic treatment.

We are glad to have the able paper on Diabetes by Dr. Henry B. Gotten of the Polyclinic. This is an able paper. He speaks authoritatively.

The North Mississippi Seven County Medical Society rendered a fine program at Holly Springs on Wednesday evening, June 15th. This society puts up a good program each time. It is growing better all the time. It is doing much good in helping to look after our medical department at Ole Miss. We are always glad to attend this this society. The president for this year is Dr. H. P. Boswell. He is doing the job with ease, dignity and efficiency. Dr. A. H. Little is the very efficient secretary. He would do honor to any medical association in the state or out.

No man needs to be so broadly educated as the practising physician, none so versatile. To know the technic of an operation or prescribe a pill does not answer that demand of today. Some working knowledge of psychology and psychiatry is of the greatest importance at this time. If every man has his price in politics, every man is a little crazy under such financial stress and strain as we are now having. People are not their normal selves. They are often undecided as to whether they will try to buck the line and go forward and longer. They are smarting under the load of debt and the worry and embarrassment it brings. Suicidal intent is in the mind of many and brighter outlook is so impossible. Some have an idea that their insurance is worth more to their families, would be, than they can possibly be. The many "spontaneous" fires are evidences in some cases that the honest working spirit in the man has been over come. The times are calling for men with a broad vision, a sympathetic heart, and a courageous soul overflowing with faith for the future. The human organism must have outward adjustments as well as inward medication and surgical plumbing. To give courage we must be courageous. To inspire hope we must be full of hope for a better day in the future. We must be a friend in deed to a clientel who is surely in need of many of the essentials of life in this time of stress. No other man carries the heavy responsibility today that the practitioner is carrying, no other profession has such an opportunity. Let us catch the vision and do the job in a big and successful manner. Let us do it with courage and with an optomistic and cheerful spirit. Service to your fellow man can not be wasted.

Dr. J. A. Rayburn and son Dr. T. H., are now located at Pontotoc. We welcome them back to our society and predict for them success in this field.

The well trained nurse is the axle to the medical profession. The good physician who utilizes her services co-operatively will soon roll up the hill to success.

There is no one thing common or of small importance in the medical profession. We need men who are experts in the application of the known medical truths.

The practising physician must now make his profit on volume of business rather than a long price to the individual patient. Henry Ford sells the cheapest car, but he has made the most money.

Anti-Rabies treatment is now furnished by the state board of health for two dollars and fifty cents. It is good service to the people to be able to get it at this price.

Our people must be taught to give little gifts to the small hospitals. It will not leave them poor, but it will enable the small hospital to give good service on a two or three dollar a day room rate.

It appears to us that some small hospitals were left off the list by the legislature that should have been on. The aid was small to each one, but we regret that any deserving ones should have been left off. It was not the fault of the hospital committee. The bill that finally passed was not our bill although it contained many of the provisions we advocated. The bill was rushed through at the very last hour and some were just overlooked we presume.

Fred W. Duckworth finished his term as president of the Mississippi State Pharmacy Association with the closing of the annual session at Natchez last week. His presidential address received much favorable comment by the local press of that distinguished and cultured city. The state association of pharmacist did itself an honor in bestowing its highest gift on Fred W. Duckworth. He is not only one of the most competent pharmacists in Mississippi, but he is much more, he stands in our highest rank as a fine type of citizen. In discussing the problems of the associated pharmacists in Mississippi, Mr. Duckworth frequently used the key words, the Golden Rule Phrase, "Live and Help to Live." If the Republicans could have struck such a keynote the party would have had some chance to win. No words could have been more timely than these just now. It is not enough to live and let live, "Live and Help Live," make your own living and in addition do a little extra and help some one else to live.

If we would only do this hard times would vanish like a ghost at the rising of the sun. There are a million ways to live and help to live before we take any action on the 18th amendment. Let Uncle Sam teach his people to make an honest living by giving service for every penny received and then do a bit extra to help the unfortunate who at times can not help himself and we would soon be a happy and a prosperous people. It is a pity that those wet bawling Republican hood-lums in Chicago could not have heard Mr. Duckworth's address and their brains could have been dry enough to have caught its vision. If the association appropriates the "keynote" of President Duckworth's address its increasing influence in our social economy will soon be felt in our state. The pharmacists constitute a great profession and one whose services are being recognized and appreciated more and more. The pharmacist is the power behind the throne to many a successful practitioner. He constitutes a very important part of the medical profession in reality. Our town is doubly blessed with efficient pharmacists and a fine type of pharmacy citizenry. We congratulate F. W. Duckworth on this splendid address and we recommend to his profession, to our profession and to the political parties of our nation his keynote, "Live and Help to Live.

Thirty-five small hospitals are to receive thirty-nine thousand dollars a year from the state for charity patients. It is not to be paid in a lump sum, but to be paid on an itemized and approved account of each patient. This is as it should be. The hospitals receiving this aid must first be approved by a board of three, one appointed by the president of the state medical association, one the president of the hospital association, and one by the president of the state nurses association. This board is composed of the following respectively, Dr. C. M. Speck of New Albany, Mr. Hamilton Crawford of Hattiesburg, Miss Dorsey R. N. of Greenville. This board will check the thirty-five hospitals listed by the state legislature at once. They are to receive only five dollars per day while doing this work and each hospital is to be assessed ten dollars to pay these expenses. This is a good plan and this is a good board. The Governor is to appoint three trustees for each hospital to approve the applicants applying for charity and to O K the bills. Two dollars per day are allowed for charity patients in wards with necessary incidentals added. This is not the bill that was sponsored by the committee selected by the medical association, but it does have many of the features of it. The amount for the small hospitals over is very meager. But we should accept it in good spirit and use it to the very best advantage of the poor people who are so much in need at this time. Let us make it the strong evidence of our bigger and better plans for the future.

Undulant Fever

A Brief Report of Seven Cases

BY OTIS S. WARR, M.D., AND
HENRY B. GOTTEN, M.D.
THE POLYCLINIC
Memphis, Tenn.

Undulant fever, an old disease only recently recognized as common to man, has become so widespread that it is fast becoming a major public health problem in all sections of the country. Prior to 1925, the disease was recognized only in goat raising districts and only 128 cases had been reported. By January, 1930, the number had grown to 2,365, tabulated from the health departments of all states of the Union, although in some states undulant fever is not a reportable disease. Of this number, 190 were in the Tri-States. Before 1928, 38 cases had been recorded in Tennessee, and 2 in Mississippi. In 1929, 89 were recorded in Tennessee, 9 in Mississippi, and 2 in Arkansas. Of the series which we present, 3 were from Memphis, 2 from Mississippi, and 2 from Arkansas.

Cattle and hogs seem to be the chief sources of infection in this country. The ingestion of the organisms through raw dairy products, particularly cow's milk, is the principal mode of infection. The skin, as well as the digestive tract, may be a portal of entry. As a result of direct contact with infected animal tissue, packing house workers, handlers of meat, farmers, and veterinarians are often affected by the disease. The incubation period seems to be from four to sixteen days.

The age distribution apparently is dependent upon a variation in susceptibility and direct exposure to infected animals. The relative immunity of children, the principal milk consumers, appears to be parallel to the immunity in calves. The sexes are infected about equally.

Undulant fever often presents a wealth of symptoms and a dearth of physical signs. The onset is usually gradual and insidious. Weakness, general malaise, headache and backache, and anorexia may precede or accompany fever, chills, sweats, and pains in the joints and extremities. Less frequent symptoms are nausea, vomiting, dizziness, bronchitis with cough and sore throat, and sore gums and teeth. Often the patient is not incapacitated by his illness, although his temperature may be surprisingly high. He may feel quite well in the morning, but as the temperature becomes elevated the symptoms return, and nocturnal febrile exacerbations may be severe.

The clinical picture varies greatly and often is so indefinite as to obscure the diagnosis. Careful differentiation must be made between typhoid fever, influenza, malaria, tuberculosis, and, less frequently, rheumatic fever and endocarditis. To confirm a clinical diagnosis, laboratory tests are necessary. The agglutina-

tion test is the best diagnostic agent, but a negative test does not exclude undulant fever or a positive test necessarily imply that the patient has the disease.

The most distinctive feature of the clinical course is the fever. It may be the rare and usually fatal fulminating type, or the undulant or continued type which may persist for weeks or months. The majority of cases are of the continued type. Chills, which sometimes are very severe, are often as constant as the fever, and may recur daily at the same time. Sweats may be mild or profuse. Headache, backache, arthralgia, muscular pains, and neuritis may appear early or late. Asthenia, loss of weight, and, in prolonged cases, anemia are almost constant findings.

Undulant fever may last only a few weeks or months or may persist for years. The average duration is about four months. The height of the agglutination titre bears some relation to the prognosis, since recovery has been most rapid in those cases in which the agglutination titre has been very high.

The treatment is essentially symptomatic. Reports of the various investigators on the efficacy of vaccines are, in general, favorable, but as yet there is no controlled basis for recognition of these products. The various dyes, used intravenously, have not given uniform results.

The 7 cases in our series varied from the mild to the severe in type. Their duration was from one to twenty months. Three patients were men and four were women. The age distribution ranged from 29 to 46 years. Brucella Abortus was uniformly the causative agent. Fever, sweats, muscular pains, and aching of the limbs and joints were constant symptoms. In every case fever was consistently of the intermittent type.

Two patients had a similar type of the disease, both being mild. These were women, aged 43 and 45. Both complained of irregular fever, chills, and aching of the limbs and joints. The agglutination tests were positive in dilutions to 1:640. Their symptoms disappeared and fever subsided in about one month.

The second case was more severe. The symptoms were intermittent fever preceded by aching and pains in the extremities. The agglutination test was positive in dilutions to 1:640.

A fourth patient also complained of chills and fever. The agglutination test was strongly positive. When she consulted us fever was recurring, but physical examination revealed only a normal pregnancy. The febrile period lasted a short time and the pregnancy terminated normally.

The fifth patient suffered more than three months from intermittent fever, chills, sweats, aching of the muscles, and nycturia. The agglutination test was positive in dilutions to 1:-2560. Blood cultures were also positive. Two months after the diagnosis was made the patient was still running a temperature.

The two most severe cases were of patients from Arkansas. Both complained of fever, chills and sweats, with the maximum temperature ranging from 101 to 104 degrees. The only other symptoms were slight burning on urination and arthralgia. Physical examinations of both were negative. The agglutination tests were positive up to 1:1280. For a period of five or six months from the onset alternate febrile and afebrile periods of approximately two weeks duration continued.

This report of seven cases does not warrant any conclusive data, but does call attention to the presence of undulant fever in the Tri-States.

Some Fundamentals of the Diagnosis and Treatment of Diabetes Mellitus

BY HENRY B. GOTTEN, M.D.
THE POLYCLINIC
Memphis, Tenn.

Diabetes mellitus is a disease which comes under the observation of physicians in all branches of medicine. Owing to the increasing number of cases seen and the complications they present, it is one of the most important diseases of which we know. The treatment must be based on a number of factors, and for this reason care should be exercised to avoid diagnostic errors. Some of the more common of these errors, as well as a few fundamental points in treatment will be discussed here.

As a rule, in the diagnosis of diabetes, too much reliance is placed on the results of the urine analysis. We assume that a patient has diabetes because sugar is found in his urine. On the other hand, we falsely assume that he does not have diabetes if a specimen of urine does not contain sugar.

The error of the first assumption is possible if we fail to regard a low renal threshold, emotional disturbances, hyperthyroidism, and cerebral lesions as possible factors in the production of glycosuria. In the second instance, the error comes about because we neglect to consider that the specimen of urine examined may have been voided when the blood sugar was below the renal threshold and therefore did not spill sugar into the urine. This is particularly true in cases of high renal threshold, some of which are as high as 300 mg. In other cases, the blood sugar recedes during the night, and if the specimen is obtained before breakfast, we are led to the erroneous conclusion that the patient does not have diabetes. Further, the symptoms prsented by the patient are often misleading. We have been taught that the cardinal symptoms of the disease are polyuria, polydipsia, and polyphagia, and have failed to recognize the condition unless they were present. These indicate starvation and dehy-

dration, however, and do not occur except in advanced stages. Moreover, many patients with severe diabetes will complain of none of these symptoms except perhaps loss of weight. Again, such signs as increase of appetite, thirst, and polyuria often disappear when acidosis is present.

We should remember also that, although diabetes is a disease which affects elderly persons principally, it is often seen in children. In the latter, the onset may be abrupt; it may follow an acute upper respiratory infection, a contagious disease, or other affections common to childhood. An extreme acidosis, or even a state of coma may characterize the onset.

The diagnosis of diabetes is made on the following clinical and laboratory findings:

(1) Symptoms of polyuria, polydipsia, and polyphagia, sugar in the urine, and a high blood sugar.

(2) Righ blood sugar without the usual symptoms of diabetes, if a sustained glucose curve is obtained.

(3) Symptoms of peripheral neuritis, failing vision, paraesthesia, vertigo, infections over the body, especially about the feet or neck, tinnitus, signs of an arteriosclerosis too advanced for the patient's age, and a glucose tolerance curve indicative of decreased carbohydrate metabolism.

The symptoms in the last group are seen in probably more than 50 per cent of cases. As these patients present themselves early, frequently no sugar is found in the urine and the condition is unrecognized until evidence of severe diabetes is present. Their symptoms are seldom relieved until the diabetes is under control.

The finding of sugar in the urine should never be ignored. If any doubt exists, a tolerance curve should be made to establish definitely the diagnosis of diabetes or show the sugar to be the result of other disturbances.

Despite the fact that the treatment of diabetes has been fairly well standardized, many patients are still being treated incorrectly. Often they are not instructed in the management of the diet; some are cautioned against eating too many sweets; others are told that a moderate amount of sweets is harmless, and that honey may be substituted for sugar; others are advised that meat should be restricted.

The more serious error, nowever, is failure to utilize insulin to advantage. If insufficient or no insulin at all is given, a reduced carbohydrate diet will not always bring about a lower blood sugar. Physicians are often afraid of insulin because of reactions frequently encountered.

In the use of insulin, it is important to give an adequate amount and to divide it correctly between the three meals. If the blood sugar tends to rise unduly during the night, a midnight dose may be required. The proper dose is arrived at by trial and error, after a sufficient quantity has been given to render the patient free from acidosis. Daily urine sugar examinations after meals, with occasional or frequent blood sugar determinations, as indicated, will guide the physician in finding the correct insulin dose.

Elderly patients with mild diabetes, who have not lost an appreciable amount of weight and show no evidence of acidosis, should not have too vigorous treatment. Although they are generally over weight, arteriosclerotic, and have some myocardial weakness, it is not necessary to rigidly restrict their consumption of carbohydrates. Further, it is often impractical and unnecessary to have the diet weighed. If the renal threshold is normal, they should be put on a diet which only moderately limits carbohydrates and fats. By this means they should gradually reach a satisfactory weight. A moderate restriction will generally suffice, also, to render them free of symptoms and to maintain the blood sugar at a normal level. Both weight and blood sugar should be checked at intervals, as it is never well to allow these patients to assume they are free of the disease.

In the more severe cases of diabetes, greater care is imperative. These patients may be young or old, and may or may not have acidosis. Their loss of weight is usually excessive. As they require meticulous attention, they should be sent to a hospital, where proper dietary control can be exercised and accurate blood sugar determinations made. They should be placed at once on a diet containing a balance between the carbohydrates, fats, and proteins. The carbohydrates need not be too strictly limited. From 100 to 150 grams a day are allowable, as the diet will thus be more palatable and the patient more likely to follow it. Patients are reluctant to follow diets too low in carbohydrates. A preliminary starvation or basal diet is contraindicated. Such a procedure tends to prolong hospitalization and make treatment more difficult, as the diet must be changed several times and the insulin dose readjusted each time the diet is changed. If the diet is stationary, only the insulin dose requires adjustment.

During hospitalization the patient must be taught how to weigh and measure his diet carefully, to sterilize a syringe, and to measure and inject insulin. He should be taught how to examine his urine and how to increase or decrease the insulin if sugar appears in the urine, or if he suffers insulin shock. He should be informed of the principles concerning diabetes, as well as its complications. He should also be instructed to see his physician at regular intervals for the proper changes in diet and insulin, or in case any complications arise. Too often, after being standardized, a patient is turned loose to look out for himself, and feeling that the physician has no more interest in him, he neglects his treatment.

The treatment of patients in coma is relatively simply if we remember a few points. Large doses of insulin, of 30, 40, or 50 units.

should be administered every two hours until some response is obtained. Meanwhile, close watch must be kept on the blood sugar. If blood sugar determinations cannot be obtained, frequent tests of urine should be made. As soon as the urine is sugar free, large amounts of glucose in the form of orange juice should be given until the patients are out of coma. Heat, fluids, and stimulants are useful adjuncts in restoring consciousness; it is doubtful that alkalies are of any benefit. Proper measures for control can then be instituted.

Insulin shock following treatment for coma is combated by the administration of adequate amounts of glucose. It should not be confused with a relapse of the coma.

Surgery in diabetes is meeting with remarkable success when combined with treatment by competent internists. By this method, diabetics, who are so frequently in need of surgical treatment, can be handled with little risk. They must be given individual attention, based on the complications present. Preliminary measures, the decision when to operate, the type of operation, the choice of anesthesia, and postoperative treatment must each receive due consideration. With proper care throughout, the results of surgery on diabetic patients should be as gratifying as on non-diabetic patients.

The treatment of diabetes mellitus should be adjusted to the patient, rather than the patient to the treatment. Patients present themselves in all stages of the disease, with numerous and varied complications, all of which should be given careful thought before treatment is begun. Over-treatment may be as harmful as under-treatment.

CONCLUSION

1. The diagnosis of diabetes is not always simple, but it should be established definitely before treatment is instituted.

2. Diabetes should be suspected in patients who complain of apparently inconsequential symptoms. It should not be overlooked in children.

3. Complications occurring in diabetes should be handled promptly, with precision and accuracy.

4. The patient should be properly instructed in the principals of diabetic treatment.

5. A close relationship and understanding should be established and maintained between the physician and patient which will keep the patient in contact with the physician at frequent intervals.

6. Diabetes is not a contra-indication to surgery if properly understood and treated.

7. The results of diabetic surgery are best when the internist and surgeon work together.

8. Treatment should be adjusted to the individual case.

The Relation of Gastric and Renal Disorders

BY SEALE HARRIS, M.D.
Birmingham, Ala.

Among the papers of interest to the general practitioner read at the recent meeting of the American Medical Association in New Orleans was one by Friedenwald and Morrison[1] entitled "Clinical Observation on the Relation of Gastric and Renal Disorders." It is the general practitioner who first sees the patient with early manifestations of failing kidney function; and in such cases if he recognizes that the anorexia, vague abdominal discomfort, nausea, vomiting and diarrhoea, and sometimes obstinate constipation are due to metabolic changes of renal origin, he can institute treatment that may prevent irreparable damage to the kidneys and myocardium. If he fails to make the correct diagnosis in such a case, and treats the symptoms as of primary gastro-intestinal origin, allowing his patient to become dehydrated and toxic from retained urinary products, his trusting patron is doomed to an early death from uremia or a damaged myocardium.

In the discussion on Friedenwald and Morrison's paper it was brought out that in any case of nausea and vomiting, with either constipation or diarrhoea in a man or woman past fifty, in which symptoms cannot be accounted for otherwise, it is safest to consider that they are due to renal dysfunction and treat the patient accordingly. The prompt aministration of sufficient fluids and soluble carbohydrates in such cases saves lives. If the patient cannot retain water and soluble carbohydrates such as orange juice, lemonade, orangeade, dextrose (cane sugar), glucose (corn syrup) solutions, and coffee or tea, at least three or four quarts a day, fluids and dextrose may be given by hypodermoclysis (five per cent solution) or intravenously (ten per cent solution). If there is constipation plain water may be given by proctoclysis after a cleansing enema. It is futile, and even harmful to give glucose or other carbohydrates per rectum, (deTakats,[2] Harris[3]). In cases of suspected renal damage salt solutions should be given sparingly, not more than 1000 c.c. a day. (Trout)[4] while sufficient fluids should be given it is unsafe to give more than 4000 c.c. a day, because of the danger of "water intoxication," (Roundtree[5]) or of overworking damaged kidneys, or of overwhelming a toxic and failing myocardium.

Of course, it is desirable to make renal function tests (phenolsulphonephthalein), and blood chemistry studies (non-protein nitrogen, urea, creatinin, carbon dioxide combining power of blood plasma, etc.) in such cases to determine the functional capacity of the kidneys and the character and degree of the toxemia; but the general practitioner, who may not have laboratory facilities available, should play safe by

treating the patient with gastro-intestinal symptoms of suspected renal origin as if he were positive of the diagnosis of primary kidney disease.

In men past fifty whose first symptoms are anorexia, nausea, vomiting and diarrhoea, unless known to be due to food infection or other demonstrable causes, an examination of the prostate, and the bladder for residual urine, may clear up the diagnosis. Not infrequently the first symptoms of urinary obstruction and retention from an enlarged prostate are nausea, vomiting and diarrhoea, and the patient may be saved from permanent renal and myocardial damage, and an early death, by recognizing the nature of the disease and administering the appropriate treatment. In such cases operation for the relief of the prostatic obstruction should be deferred until all evidences of uremic symptoms have subsided. The toxic patient with gastro-intestinal manifestations of uremia is a bad risk for any kind of a prostatic operation.

Friedenwald and Morrison also discussed renal disease of gastro-intestinal origin, particularly the kidney insufficiency seen in pyloric, or high intestinal obstruction. They stressed the fact that the toxemia, and alkalosis, that are such dangerous complications in neglected duodenal ulcers with pyloric obstruction and gastrectasis, may be associated with renal insufficiency; and that in such cases, prolonged and thorough preparation of the patient for operation will lower the mortality in gastric surgery. Neither the general practitioner nor the specialist should ever lose sight of the very intimate physiologic relation between the kidneys and the digestive system.

1. Friedenwald, Julius, and Morrison, Samuel: Clinical Observations on the Relation of Gastric and Renal Disorders. Read in the section on Gastro-Enterology of the American Medical Association, New Orleans, May 13, 1932.

2. deTakats, Geza: Push fluids, the surgeon's postoperative order. Am. J. Surg. 11:39-44, (January) 1931.

3. Harris, Seale: The futility of glucose enemata. Jour. Med. Assn. Ala. 1, 6:260-261 (Dec. 1931.)

4. Trout, Hugh: Proctoclysis: An experimental and clinical study. South. M. J. 6:791-794, (Dec. 1913)

5. Roundtree, L. G.: Water Intoxication. Arch. Int. Med. 32:157-174. (1923).

Pyelitis*

BY G. P. SANDERSON, M.D.
Vicksburg, Miss.

I feel I should apologize for writing a paper on so trite a subject but it is probably well for all of us at times to give a more detailed study to the commonplace things. It is not unusual to see the commonplace condition overlooked, in our search for the unusual.

Pyelitis is defined by Osler as inflamation of the kidney pelvis and the conditions, which result from it. However, the terms pyelonephritis and pyonephrosis are no longer considered under different headings and are all grouped under the heading of pyelitis. At one time it was thought that lesions invilving only the pelvis (pyelitis) or extending from the pelvis into the kidney (pyelonephritis) were always the result of infection from below, and that the more intense infections (abscess, etc.) were blood borne. Since it has been proven that hemogenic infection may set up a lesion confined entirely to the kidney pelvis, all three conditions are considered under one terminology.

ETIOLOGY—Pyelitis is, the result of the inplantation in the pelvis of bacteria from some focus in the body by ways of the blood stream, or the passage up the ureter of infected material from the bladder, when for some reason the kidney cannot eliminate the infective material. The factors that influence the ability of the kidney to eliminate the infectious material may be general or local. Under the general heading would be considered anemia, some intercurrent disease or malnutrition; under the local causes, displacement of the kidney, nephritis, pressure on the ureter by a possible tumor, kinking of the ureter, etc. We must not forget that occasionally certain drugs taken internally set up an inflammatory condition in the kidney pelvis. Of these turpentine is probably the outstanding example.

SYMPTOMS—The patient with acute pyelitis gives the picture of any acute general infection, with only pain over the kidney to identify the disease, Intermittent chills and fever with sweats together with pain over one or both kidneys will usually make the diagnosis. The pain may be dull aching in character or may later, during the passage of a mass of pus cells, closely simulate renal colic. The urine will show a few pus and blood cells; may be either acid or alkaline, depending on the infecting organisms; and the albuminuria due probably to the presence of the blood cells, is usually of a higher grade than the pyuria. As the condition becomes more chronic the general symptoms persist and pyuria becomes more pronounced. In addition there generally then appear the symptoms due to irritation of the lower tract, namely, frequency, burning, disuria, urgency, difficulty, or tenesmus. Fever is almost always present; pyuria is constant and most always present; pyuria is constant and even with the absence of pus in the urine, it must be remembered that the pyelitis may be confined to one side and the ureter of that kidney temporarily blocked and thus no pus appear in the urine at the time of examination.

Polyuria is an indication of renal damage and is often associated with partial or intermittent

*Read before the Issaquana-Sharkey-Warren Counties Medical Society, Vicksburg, Miss., June 14, 1932.

obstruction. Tumor may or may not be noted.

DIAGNOSIS: In diagnosis the following points must be determined:

(1) The identy of the infecting organism.

(2) The source of the infection.

(3) The severity and extent of the lesion.

(4) The amount of damage done to the secreting renal parenchyma, and

(5) Whether obstruction is present and if so its cause.

The examination of the urine is of paramount importance. Low specific gravity indicated renal damage and a strongely alkaline, ammonical urine indicates an infection with urea-splitting organisms. Albumin is of minor value, as its presence may be due to other causes. The presence of bacteria is proof positive that infection exists somewhere in the urinary tract. If cocci are found a gram stain should be made and if bacilli are found appropriate efforts at eliminating the possibility of tuberculosis should be employed, even to the injection of a guinea pig in doubtful cases.

CYSTASCOPY is indicated subject to the condition of the patient. By this means many important facts are elicited, i. e. whether or not there is a cystitis and if so whether it is primary or secondary, whether one or both kidneys are involved, and the respective functions of the kidneys, as well as a general examination of the bladder for calculus, obstruction, tumor, etc. X-ray examination made possible by the cystoscope may give valuable additional information. In this connection I may say that sodium bromide solution seems still to be the most effective media for pyelography though lipsiodol, gives a beautiful outline of the tract. The main object to the latter is the difficulty of injecting it through small catheters. The various preparations used intravenously are usually not satisfactory for definate pelvis outline though they are of some value.

TREATMENT: Remove the cause, often times more easily said than done. The elimination of all possible foci, the correction of mechanical abnormalities and the treatment of the condition itself. Fluids should be taken freely, particularly alkalies. Urinary antiseptics are of some value. Personally, I have found pyridium tablets very effective. Vaccine therapy gives good results in some cases but lavage of the kidney pelvis with some weak silver preparation seems to be most beneficial in the general run of cases. The general treatment of the patient is the same as for any other condition, i.e., tonics, nourishing food, milk in abundance and above all things fluids.

References: Osler; Hugh Young.

Tonsillitis*

BY DR. J. G. MANCIL
Indianola, Miss.

This subject, upon which I wish to talk, is one which is such a common malady that it seems nothing further can be said about it.

What can one say concerning tonsillitis? Tonsillitis is any inflammatory process involving the tonsils and often extending to adjacent structures. This group of diseases may, for convenience, very well be considered under five heads, namely: acute tonsillitis, chronic, streptococcus, sore throat, Vincent's angina, pertitonsillar abscess or quinsy. I will discuss each separately. Acute Tonsillitis is an acute infectious disease characterized principally by an inflammatory process involving the tonsils and often extending to adjacent structures. This disease is extremely common, practically all ages affected. It is relatively rare in infancy and old age. It is most frequently found during childhood and early adult life, and becomes less common as old age approaches. The frequency which the disease is found will be largely influenced by the care exercised in making routine examinations. This applies practically to young children who are not able to make complaint as to the location of pain. Very often, even with adults, considerable involvement may be present without sufficient discomfort to cause the patient to mention the symptoms if particular inquiry is not made. Tonsillitis is of much importance, not only from the amount of actual temporary discomfort entailed, but also on account of the many possibilities of trouble. Acute tonsillitis may be transmitted by any means that causes an individual to come in contact with infected secretions from the mouth of a patient. It is highly probably that the disease is often conveyed by the use of public drinking cups and improperly cleaned drinking and eating utensils; it may also be conveyed by kissing, exposure to cold and, no doubt, may result from the same general cause as colds. The most common organisms responsible for this disease are the streptococcus, staphyloccus and pneumococcus. The most important symptoms of this condition are chilliness or rigors, temperature usually very high, 103 to 104, and in some instances higher, pain almost constant in the beginning, general aching, especially head, back of neck and lower extremities; nausea is not a constant symptom but is often seen in early stage, and a factor that is probably responsible is the excessive secretion present in many cases; usually there is disinclination to take food, on account of nausea and pain of swallowing. In many cases where there is no anorexia, swallowing may cause such discomfort as to prevent the patient from taking food. The local signs, found upon examination of tonsils, reveal con-

*Read before the Delta Medical Society, Cleveland, Miss.

siderable redness and extension to surrounding structures, especially the pillars of tonsils; the tonsils being more or less enlarged and may have deposits in the crypts. These deposits usually have the appearance of spots or white lines, instead of patches. These deposits differ decidedly from diphtheria and Vincent's angina and do not bleed when removed. From a standpoint of differential diagnosis, a culture is invaluable and should be made in all cases of sore throat. In acute tonsillitis, you will invariably find increase in total white count and neutrophil percentage and, in some cases, these changes are very marked. CHRONIC TONSILLITIS is probably more frequent than the general practitioner suspects and a thorough investigation of the tonsils should be an indispensable part of the general examination. Chronic tonsillitis is important largely on account of the possibility of other troubles. A focus of chronic infection in the throat may materially interfere with the patient's well-being from many standpoints. The discovery of this condition depends largely upon the character of investigation made. We are often consulted for ailments that are purely secondary conditions and so often the tonsils are the real focus of infection. The temperature in chronic tonsillitis may be very slight, or no elevation at all; cough is not constant. Very often the focus of infection in the tonsils is a factor in the predisposition of the patient to frequent attacks of colds, especially during the winter months. The cervical glands, in relation to the tonsils, may show more or less enlargement. Upon examination of the throat, the tonsils may be found to be large irregular masses projecting toward the middle line, and often cause mechanical trouble by their presence. On the other hand, it is not unusual to find the tonsil apparently normal in size but, when pressure is made, pus can be squeezed out of the crypts. Usually the breath has an offensive ordor—due to deposits of hard cheesy masses in the crypts.

Streptococcol sore throat differs so little from that of acute tonsillitis that it will be covered briefly. Practically all constitutional symptoms are the same. Upon examination of the throat, more or less extensive white membrane will be found. This has a tendency to spread to surrounding structures, often times along roof of mouth until it reaches the upper incisors. If membrane is removed, a bleeding surface is left. The only positive way to dif ferentiate this condition from diphtheria is by culture. Vincent Angina is one of the forms of acute sore throat. Its discussion properly comes under the head of tonsillitis, as the tonsils are most frequently involved. It is a moderately serious disease, requiring careful handling. The characteristic signs are moderate or slight but, at other times, violent pain in swallowing or talking. The onset, with symptoms of subacute or mild tonsillitis, may be malaise headache, chilly sensations, slight fever (102 to 102 1-5) unilateral enlargement of cervical glands, especially in children. Presence of grayish white

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patch or patches in the earlier stages are visible upon the tonsils, most frequent at its upper part, spreading later to the soft palate, the other tonsil, pharynx or the gums. The patches are surrounded by a red inflamed areola but separated from each other by healthy tissue. On removal of the membrane, which is granular and cheesy in consistency, an ulcerative area is exposed which bleeds freely and is soon covered by a new membrane. The membrane may spread like diphtheria and just as quickly. Examination of a stained smear will quickly settle the diagnosis. Microscopic examination of a stained smear showing a fusiform bacillus twice as long as wide, pointed at the ends, in symbiosis with a spirillum forming a network around the bacilli.

Peritonsillar abscess or quinsy is fairly frequent and many patients show a marked tendency to recurrent attacks unless the tonsils are removed. The early constitutional symptims are practically the same as acute tonsillitis, except that this may be more pronounced and persistent. Almost from the beginning, the patient has very anxious expressive voice, greatly impaired due to excessive secretions and swelling. There is almost always considerable swelling externally; swallowing is very difficult and often times there is inability to swallow. Upon examination, considerable redness of tonsils and surrounding tissue will be found; also tonsils swollen and bulging; the swelling also marked above anterior pillars and extending to uvula. The most important symptoms and differential diganosis have been given under each heading; therefore, will not discuss further. There are, however, two other conditions which have not been mentioned in this paper, namely, diphtheria and syphilitic sore throat. These conditions should always be considered and, when in doubt as to the offending infection in any sore throat, a culture is absolutely necessary to clear up the diagnosis. As to treatment, there is no specific treatment for this disease. It is one of those conditions in which much can be done for the relief of suffering, for shortening the course of the disease and limiting complications. General care of patient is necessary. Rest is often neglected, but when we consider the extent to which there is a tendency to involvement of kidneys and heart and other body structures, we are impressed with the necessity for sufficient rest in bed. Drastic purgations not desirable, but sufficient intestinal elimination should be maintained. Light diet—the food given will have to be influenced not only by the temperature but also by the ability of the patient to swallow. Medical treatment is purely symptomatic. We have several objects in view, to produce relief from pain, to modify the course of the disease and to limit the possibilities of complications. My best results are obtained by the use of salicylates, preferably acetyl salicylic acid combined with bismuth subnitrate if there is any tendency to gastric disturbance.

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MEDICAL SOCIETY
North Mississippi
at Holly Springs, Mississippi
June 15, 1932
PROGRAM

Invocation by Rev. Golding, Holly Springs.
Dinner, "Dutch"
Business Session
Intermission, Five Minutes
Scientific Section

(1) "Digestive and Infectious Diarrheas in Children" by Dr. D. R. Moore, Byhalia.

Discussion opened by Drs. W. C. Lester and W. W. Phillips.

(2) "Instrumental correction of Prostatic Obstruction" by Dr. T. D. Moore, Memphis, Tenn.

Discussion opened by Drs. R. G. Grant and George Brown.

(3) "Diagnosis and Treatment of Seasonal Hay Fever" by Dr. A. H. Little, Oxford.

Discussion opened by Drs. Ira B. Seale and S. E. Eason.

(4) "Anesthesia in Surgery of the Thyroid" by Dr. L. S. Brown, Water Valley.

Discussion opened by Dr. J. C. Culley and C. M. Speck.

(5) "Traumatic Surgery of the Extremities" A Motion Picture, Courtesy of Davis & Geck, Inc., Brooklyn, N. Y.

Regular Quarterly Meeting of the
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MEDICAL SOCIETY
Held at Amory, Tuesday, June 21, 1932
PROGRAM

1. Meeting called to order, Dr. W. C. Spencer.

2. Invocation, Rev. J. F. Measell.

3. "Diorrhea of Infants and Children," Dr. J. F. Eckford.

Discussion opened by Drs. Hood and Reed.

4. "Abscess of the Liver," Dr. R. H. Christian.

Discussion opened by Drs. L. C. Feemster, Jr. and R. P. Donaldson.

5. "The Value of the Sex Harmone Test in Gynecology," Dr. W. T. Black, Memphis, Tenn.

6. "Radium Therapy with Report of a few Cases," Dr. W. H. Anderson.

Discussion opened by Drs. J. R. Williams and M. Q. Ewing.

7. Business Session.

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